City of Seattle
Seattle City Employees' Retirement System
Board of Administration

Cecelia M. Carter, Executive Director

October 21, 2011

**Subject: Review 2012 Medical Plan Changes**

Dear City of Seattle Retiree,

The City's Annual Enrollment period for retiree medical plans is scheduled for Tuesday, November 1 through Wednesday, November 23, 2011. The following summarizes what you need to do to have the medical coverage you want starting January 1, 2012.

- **If you want to stay in your current medical plan,** no action is necessary. The new premium deduction amount will start with your December 31, 2011 pension check.
- **If you are changing medical plans offered through the City,** you must fill out an enrollment form and submit it to the Retirement Office postmarked no later than Wednesday, November 23, 2011. Call our office at (206) 386-1293 or toll free at 1-877-865-0079 to request an enrollment form (any customer service representative will be able to assist you). Your new coverage will go into effect January 1, 2012. The new premium deduction amount will start with your December 31, 2011 pension check.
- **If you want to drop/cancel your City retirement medical plan coverage for 2012,** you must notify the Retirement Office in writing by Thursday, December 15, 2011.

Please read the rest of this letter and the enclosed information to understand your options and upcoming changes to the plans. The benefit comparisons and rate sheets are also available online at seattle.gov/retirement/medical_info.htm or from the Retirement Office at (206) 386-1293 (toll free: 1-877-865-0079).

## Medical Plans for Retirees and Dependents under Age 65

The same four medical plans are available to retirees and dependents under age 65 who are currently enrolled in a City retiree group plan; see the enclosed comparison chart for more information. Notable changes to these plans for 2012 include:

**Aetna Preventive and Traditional Plans**

| | |
|---|---|
| • Add coverage of Gender Reassignment Services | – Medical and surgical services covered according to Aetna clinical guidelines* |
| • Add coverage of Temporomandibular Joint Services | – Non-surgical services covered up to $5,000 lifetime maximum<br>– Surgical services covered according to Aetna clinical guidelines* |
| • Add Aetna's Radiology Management Program | – Pre-certification required for high-tech radiology services such as PET scans, MRIs. (**Not** required for services such as xrays, ultrasounds, and mammograms.)<br>– Your network provider is responsible for getting approval |
| • Add Aetna's RxCheck Pharmacy Review | – Enhanced safety measures<br>– Your physician may receive calls/letters about your prescriptions |
| • Add Aetna's Specialty Pharmacy Program | – Provides care management and special handling for high cost drugs; usually injectables<br>– Courtesy call after 1st prescription fill at a retail location |
| • Clarify coverage of Short Term Rehabilitation Services | – Physical, Massage, Occupational and Speech Therapies for non-chronic conditions<br>– Coverage subject to Aetna's medical necessity review; they may request documentation at any time, usually with 16th visit.<br>– Removes 60-visit limit |

*Visit http://www.aetna.com/healthcare-professionals/policies-guidelines/clinical_policy_bulletins.html

**Group Health Standard and Deductible Plans**

| | |
|---|---|
| • Add coverage of Gender Reassignment Service | – Medical and surgical services covered according to Group Health clinical guidelines |
| • Modify coverage of Temporomandibular Joint Services | – $1,000 annual benefit maximum removed<br>– $5,000 lifetime benefit maximum remains in place |

If you have specific questions about the plans, call the medical plan providers directly:

- City of Seattle Preventive or Traditional (Aetna): 1-877-292-2480
- Group Health Deductible: 1-888-901-4636 (Group #0961100)
- Group Health Standard: 1-888-901-4636 (Group # 1004400)

## Medicare Medical Plans for Retirees and Dependents Age 65 and Over

The City will continue to offer medical plans for Medicare-eligible individuals through the same insurance carriers as last year; see the enclosed comparison chart for more information. Notable changes to these plans for 2012 include:

**Aetna Medicare Plan (PPO)**
On January 1, 2012, the prescription drug portion of the Aetna Medicare Plan will change; the remaining medical benefits are unchanged. **This plan replaces both Aetna plans that were offered in 2011.** The City is switching to this custom design to retain more control over prescription drug plan design changes in the future.

- **New Features:** The copayments for the new plan are slightly lower than those in the Open B (B6) plan. And the copayments are higher than those for the Open A (O6) plan.
- **Automatic Renewal:** If you are currently enrolled in an Aetna Medicare Plan, you will be enrolled *automatically* in the new Aetna Medicare Plan (PPO) effective January 1, 2012, unless you submit paperwork to switch to another company's plan. If you want to stay with Aetna, you do not need to take any action.
- **Higher Rate:** The 2012 rate represents a decrease of 15% for those currently enrolled in the Open A (O6) plan. It's a 20% increase for those in the Open B (B6) plan.

**Group Health Medicare Clear Care HMO**
On January 1, 2012, the City's current Group Health Medicare Clear Care HMO Plan will be replaced by a slightly different plan. Group Health significantly reduced the number of Medicare plans they offer employers in order to streamline communications and administration.

- **New Features**: Some of the differences are: the office visit copayment reduces from $15 to $10 and the out-of-pocket maximum increases from $1,000 to $2,500. There will no longer be a charge for mammograms, and the emergency room copay increases from $50 to $65.
- **Automatic Renewal:** You will be automatically enrolled in the Clear Care plan effective January 1, 2012, unless you submit paperwork to switch to another company's plan. If you do not want to change plans, you do not need to take action.
- **Higher Rate:** While the 2012 rate represents a 48% increase over the 2011 rate, it represents only a 12% total increase from the 2010 rate, and is in line with rates of our other plans.

**Secure Horizons (Now United Healthcare)**

- **New Features:** Other than a name change, the Medicare plan through United Healthcare (formerly called Secure Horizons) is essentially the same. The full name is now United Healthcare Medicare Complete HMO, shortened on the comparison chart to United Healthcare Medicare HMO.

- **Automatic Renewal:** If you are currently enrolled in the Secure Horizons Plan, you will be automatically enrolled in the United Healthcare plan effective January 1, 2012, unless you submit paperwork to switch to another company's plan. If you do not want to change plans, you do not need to take action.
- **Higher Rate:** The 2012 rate represents a 10% increase over the 2011 rate.

If you have specific questions about the plans, please call the medical plan providers directly:

- Aetna Medicare Plan (PPO): 1-800-307-4830
- Group Health Clear Care: 1-888-901-4636 (Group # 0335500)
- United Healthcare Medicare Complete HMO: 1-866-622-8055 (Group # 801855)

**Dropping Your Medical Coverage Through the City**

*If your date of retirement was November 30, 2009, or earlier* and you drop/cancel your City retirement medical coverage, you will not be permitted to return to a City retiree medical plan in the future.

*If your date of retirement was December 1, 2009, or later* and you drop/cancel your City retirement medical coverage, you will only be permitted to return to a City retiree medical plan in the future if you can prove continuous group coverage has been maintained since leaving the City plan.

**Medical Plan Enrollment**

If you want to change your medical plan, please contact our office at **(206) 386-1293** or our toll free number at **1-877-865-0079** to request an enrollment form. ***If you do not want to make a change, no action is necessary.*** **Please note:** the Benefits Unit and Retirement Office staff cannot compare the plans or counsel you on your choice. We are not licensed insurance agents and cannot offer financial advice.

Remember, the annual enrollment period ends Wednesday, November 23, 2011. An envelope containing your completed enrollment form must be postmarked on or before November 23, 2011. We will not process forms received with a postmark date after November 23, 2011, and you will remain on your current plan.

If you have questions about Annual Enrollment, which ends November 23, call:
(206) 386-1293 (toll free: 1-877-865-0079). See the SCERS website to review detailed plan booklets for the 2011 plans: seattle.gov/retirement/medical_info.htm

Sincerely,

Cecelia M. Carter
Executive Director

# CITY OF SEATTLE

## Most Retiree
## 2012 Rates

| | Under Age 65 | Disability Medicare Eligible Under Age 65 | Medicare Eligible 65 and Over |
|---|---|---|---|
| **City of Seattle Traditional** | | | |
| Retiree | $783.44 | $310.05 | Not Available |
| Spouse / Domestic Partner | $705.68 | $280.37 | Not Available |
| 1st Child under age 26 | $226.55 | Not Available | Not Available |
| ***All*** Additional Children (not each child) under age 26 | $175.18 | Not Available | Not Available |
| ***Each*** disabled child past the limiting age | $336.12 | Not Available | Not Available |
| **City of Seattle Preventive** | | | |
| Retiree | $847.57 | $334.73 | Not Available |
| Spouse / Domestic Partner | $761.38 | $301.84 | Not Available |
| 1st Child under age 26 | $230.70 | Not Available | Not Available |
| ***All*** Additional Children (not each child) under age 26 | $173.85 | Not Available | Not Available |
| ***Each*** disabled child past the limiting age | $351.74 | Not Available | Not Available |
| **Group Health Traditional** | | **GH Clear Care** | **GH Clear Care** |
| Retiree | $472.79 | $248.15 | $248.15 |
| Spouse / Domestic Partner | $472.79 | $248.15 | $248.15 |
| 1st Child under age 26 | $275.35 | Not Available | Not Available |
| ***Each*** Additional Child under age 26 | $254.41 | Not Available | Not Available |
| ***Each*** disabled child past the limiting age | $275.35 | Not Available | Not Available |
| **Group Health Deductible** | | | |
| Retiree | $434.65 | Not Available | Not Available |
| Spouse / Domestic Partner | $434.65 | Not Available | Not Available |
| 1st Child under age 26 | $253.15 | Not Available | Not Available |
| ***Each*** Additional Child under age 26 | $233.87 | Not Available | Not Available |
| ***Each*** disabled child past the limiting age | $253.15 | Not Available | Not Available |
| **United Healthcare Medicare Complete HMO** | | | |
| HMO (each enrollee) | Not Available | Not Available | $261.81 |
| **Aetna Medicare Plan (PPO)** | | | |
| Washington State Resident | Not Available | Not Available | $187.00 |
| Non-Washington State Resident | Not Available | Not Available | $257.98 |

# City of Seattle
# 2012 COBRA Premium Rates

## MEDICAL

| Employee Group | City of Seattle Preventive | City of Seattle Traditional | Group Health Standard | Group Health Deductible |
|---|---|---|---|---|
| Most Employees, CMEO, Library, SHA & LEOFF II (Non-Represented) | $1070.36 | $968.28 | $987.19 | $909.19 |
| LEOFF I (Non-Represented) | $1070.36 | $785.76 | $987.19 | $909.19 |
| SPMA (LEOFF I) | $1070.36 | $785.76 | $987.19 | $909.19 |
| SPMA (LEOFF II) | $1070.36 | $968.28 | $987.19 | $909.19 |
| Local 77 | $1378.66 | $1396.83 | $1137.10 | N/A |
| Fire Chiefs (LEOFF I) | $1070.36 | $785.76 | $987.19 | $909.19 |
| Fire Chiefs (LEOFF II) | $1070.36 | $968.28 | $987.19 | $909.19 |
| SPOG (LEOFF I) | $1349.83 | $997.61 | $1205.88 | $889.81 |
| SPOG (LEOFF II) | $1349.83 | $1201.93 | $1205.88 | $889.81 |

## DENTAL

| Employee Group | Washington Dental Service | Dental Health Services |
|---|---|---|
| Most Employees, CMEO, Library & SHA | $117.59 | $143.17 |
| LEOFF I & II (Non-Represented) | $117.59 | $143.17 |
| SPMA (LEOFF I & II) | $117.59 | $143.17 |
| Local 77 | $126.79 | $165.48 |
| Fire Chiefs (LEOFF I & II) | $117.59 | $143.17 |
| SPOG (LEOFF I & II) | $127.85 | $165.48 |

## VISION

| Employee Group | Vision Service Plan | VSP Buy-Up |
|---|---|---|
| Most Employees, CMEO, Library & SHA | $8.85 | $20.11 |
| LEOFF I & II (Non-Represented) | $8.85 | $20.11 |
| SPMA (LEOFF I & II) | $8.85 | $20.11 |
| Local 77 | $11.48 | N/A |
| Fire Chiefs (LEOFF I & II) | $8.85 | $20.11 |
| SPOG (LEOFF I & II) | $27.90 | N/A |

# 2012 Medical Benefits Highlights – Most City of Seattle Retirees Under Age 65

The purpose of this document is to help you make decisions; it is not a contract. Details are provided in your medical plan booklet.

| Group Health Cooperative (GHC)* | | City of Seattle Traditional Plan* | | City of Seattle Preventive Plan* | |
|---|---|---|---|---|---|
| **Standard Plan** | **Deductible Plan** | **Aetna In-Network** | **Out-of-Network** | **Aetna In-Network** | **Out-of-Network** |
| **Deductible** (per calendar year) | | | | | |
| No Deductible | $200 per person<br>$600 per family<br>Deductible applies as noted except for prescriptions, preventive visits, ambulance, and durable medical equipment. | $400 per person<br>$1,200 per family<br>Deductible applies to most services, except as noted. Deductible does not apply for prescriptions or when the Inpatient co-pay or emergency room co-pay applies. | $1,000 per person<br>$3,000 per family | $100 per person<br>$300 per family<br>Deductible applies to most services, except as noted. Deductible does not apply for prescriptions or when the Inpatient co-pay or emergency room co-pay applies. | $450 per person<br>$1,350 per family |
| **Annual Out of Pocket Maximum (OOP Max)** Excludes deductible, if applicable. Aetna Copays do not apply towards OOP Max. | | | | | |
| $2,000 per person<br>$4,000 per family | $2,000 per person<br>$6,000 per family | $1,000 per person<br>$3,000 per family | $2,000 per person**<br>$6,000 per family* | $2,000 per person<br>$4,000 per family | $3,000 per person*<br>$6,000 per family* |
| **Hospital Copay** | | | | | |
| $200 per admission | Deductible applies | $200 copay per admission | $200 copay per admission | $200 copay per admission | $200 copay per admission |
| **Hospital Pre-admission Authorization** | | | | | |
| Except for maternity or emergency admissions, must be authorized by GHC | | Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission. Member responsible for obtaining precertification of out-of-network care. | | Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission Member responsible for obtaining precertification of out-of-network care. | |
| **Choice of Providers** | | | | | |
| All care and services must be approved and/or provided by GHC or GHC designated providers. Members may self-refer to most GHC specialists. | | Aetna contracted providers. No primary care physician selection or referrals required. Aexcel*** specialists must be used in designated specialty areas to receive the maximum benefit. | Any licensed, qualified provider of your choice. Expenses paid based on recognized charges*. You pay the difference between recognized and billed charges. | Aetna contracted providers. No primary care physician selection or referrals required. Aexcel** specialists must be used in designated specialty areas to receive the maximum benefit. | Any licensed, qualified provider of your choice. Expenses paid based on recognized charges*. You pay the difference between recognized and billed charges. |
| **COVERED EXPENSES** | | | | | |
| **Acupuncture** | | | | | |
| $15 copay for up to 8 visits per condition per year self-referred. Additional visits when approved by plan. | $15 copay for up to 8 visits per condition per year self-referred. Additional visits when approved by plan. Deductible applies. | Paid at 80%<br>Maximum of 12 visits per calendar year in- and out-of-network combined. | Paid at 60% | Paid at 100% after $15 copay<br>All acupuncture services are subject to ongoing review and approval by Aetna for medical necessity. | Paid at 60% |
| **Alcohol/Drug Abuse Treatment** | | | | | |
| Inpatient: Paid at 100% after $200 copay<br>Outpatient: Paid at 100% after $15 copay | Inpatient: Paid at 100% after deductible<br>Outpatient: Paid at 100% after $15 co-pay. Deductible applies. | Inpatient: Paid at 80% after $200 copay<br>Outpatient: Paid at 80% | Inpatient: Paid at 60% after $200 copay<br>Outpatient: Paid at 60% | Inpatient: Paid at 90% after $200 copay<br>Outpatient: Paid at 100% after $15 copay | Inpatient: Paid at 60% after $200 copay<br>Outpatient: Paid at 60% |
| **Contraceptives** | | | | | |
| For contraceptive drugs and devices, see Prescription Drug benefit | | IUDs and Depo Provera covered as medical benefits. See Prescription Drug benefit. | | IUDs and Depo Provera covered as medical benefits. See Prescription Drug benefit. | |
| **Durable Medical Equipment** | | | | | |
| Paid at 80% | Paid at 80% | Paid at 80% | Paid at 60% | Paid at 90% | Paid at 60% |
| **Emergency Medical Care** | | | | | |
| ➢ **Urgent Care Clinic** | | | | | |
| Paid at 100% after $15 copay | $15 copay. Deductible applies. | Paid at 80% | Paid at 60% | Paid at 100% after $15 copay (no fee for preventive care) | Paid at 60% |
| ➢ **Emergency Room (copays waived if admitted)** | | | | | |

| Group Health Cooperative (GHC)* | | City of Seattle Traditional Plan* | | City of Seattle Preventive Plan* | |
|---|---|---|---|---|---|
| **Standard Plan** | **Deductible Plan** | **Aetna In-Network** | **Out-of-Network** | **Aetna In-Network** | **Out-of-Network** |
| GHC facility: $100 copay<br>Non-GHC facility: $150 copay | GHC facility: $100 copay<br>Non-GHC facility: $150 copay. Deductible applies | Paid at 80% after $150 copay | Paid at 80% after $150 copay. If non-emergency, paid at 60% after copay. | Paid at 90% after $150 copay | Paid at 90% after $150 copay. If non-emergency, paid at 60% after copay. |
| ➢ **Ambulance** | | | | | |
| Paid at 80%.<br>GHC-initiated non-emergency transfers are paid at 100% | Paid at 80%.<br>GHC-initiated non-emergency transfers are paid at 100% | Paid at 80% when medically necessary.<br>Non-emergency transportation must be approved in advance by Aetna. | | Paid at 90% when medically necessary.<br>Non-emergency transportation must be approved in advance by Aetna. | |
| **Gender Reassignment Services** | | | | | |
| Covered as any other service; copays/coinsurance depend on type and location of service provided. | Covered as any other service; copays/coinsurance depend on type and location of service provided. | Covered as any other service; copays/coinsurance depend on type and location of service provided. | Covered as any other service; copays/coinsurance depend on type and location of service provided. | Covered as any other service; copays/coinsurance depend on type and location of service provided. | Covered as any other service; copays/coinsurance depend on type and location of service provided. |
| **Hearing Aids (per ear, every 36 months)** | | | | | |
| Up to $1,000 | Up to $1,000 | Up to $1,000<br>In-network coinsurance applies whether purchased in- or out-of-network. Deductible does not apply. | Up to $1,000 | Up to $1,000<br>In-network coinsurance applies whether purchased in- or out-of-network. Deductible does not apply. | Up to $1,000 |
| **Home Health Care** | | | | | |
| Paid at 100% when authorized.<br>No visit limit. | Paid at 100% when authorized.<br>No visit limit. | Paid at 80%<br>Maximum benefit of 130 visits per calendar year for in- and out-of-network combined | Paid at 60% | Paid at 90%<br>Maximum benefit of 130 visits per calendar year for in- and out-of-network combined | Paid at 60% |
| **Hospital Inpatient** | | | | | |
| Paid at 100% after $200 copay per admission | Paid at 100% after deductible. | Paid at 80% after $200 copay. Physician services paid at 70% if Aexcel** specialist not used in specialty areas. | Paid at 60% after $200 copay | Paid at 90% after $200 copay. Physician services paid at 80% if Aexcel** specialist not used in specialty areas. | Paid at 60% after $200 copay |
| **Hospital Outpatient** | | | | | |
| Paid at 100% after $15 copay | $15 copay. Deductible applies. | Paid at 80% after deductible. Physician services paid at 70% if Aexcel** specialist is not used in specialty areas. | Paid at 60% after satisfaction of deductible | Paid at 90% after deductible. Physician services paid at 80% if Aexcel** specialist is not used in specialty areas. | Paid at 60% after satisfaction of deductible |
| **Hospice** | | | | | |
| Paid at 100% when authorized | Paid at 100% when authorized | Paid at 80% | Paid at 60% | Paid at 90% | Not covered |
| **Maternity Care** (delivery & related hospital) | | | | | |
| Paid at 100% after $200 copay | Deductible applies. | Paid at 80% after $200 copay | Paid at 60% after $200 copay | Paid at 90% after $200 copay | Paid at 60% after $200 copay |
| **Maternity Care** (prenatal and postpartum) | | | | | |
| Paid at 100% after $15 copay | $15 copay. Deductible applies. | Paid at 80% | Paid at 60% | Paid 100% after one $15 copay | Paid at 60% |
| **Mental Health Care** (inpatient) | | | | | |
| Paid at 100% after $200 copay | Paid at 100% after deductible. | Paid at 80% after $200 copay | Paid at 60% after $200 copay | Paid at 90% after $200 copay | Paid at 60% after $200 copay |
| **Mental Health Care** (outpatient) | | | | | |
| Paid at 100% after $15 copay per individual, family or couple session. | $15 copay per individual, family or couple session. Deductible applies. | Paid at 80% after deductible | | Paid at 100% after $15 copay | Paid at 60% after deductible |

| Group Health Cooperative (GHC)* | | City of Seattle Traditional Plan* | | City of Seattle Preventive Plan* | |
|---|---|---|---|---|---|
| **Standard Plan** | **Deductible Plan** | **Aetna In-Network** | **Out-of-Network** | **Aetna In-Network** | **Out-of-Network** |
| **Physician Office Visit** | | | | | |
| Paid at 100% after $15 copay. | Paid at 100% after $15 copay. Deductible applies. | Paid at 80% | Paid at 60% | Paid at 100% after $15 copay per visit (waived for preventive care) | Paid at 60% |
| **Prescription Drugs** (retail) | | | | | |
| For a 30 day supply:<br>**Generic**: $15 copay<br>**Brand:** $30 copay<br>Contraceptive drugs and devices are covered subject to the pharmacy copay. | For a 30-day supply:<br>**Generic**: $15 copay<br>**Brand:** $30 copay<br>Contraceptive drugs and devices are covered subject to the pharmacy copay. | For a 31-day supply:<br>**Generic**: 30% coinsurance.<br>**Brand**: 40% coinsurance<br>The minimum coinsurance is $10, or actual cost of the drug if less.<br>Maximum is $100 per drug. | Not covered | For a 31-day supply:<br>**Generic**: 30% coinsurance<br>**Brand:** 40% coinsurance<br>The minimum coinsurance is $10, or actual cost of the drug if less. Maximum is $100 per drug. | Not covered |
| Copays do not apply to OOP Max. Smoking cessation prescription drugs not subject to pharmacy copay. | Copays do not apply to OOP Max. Smoking cessation prescription drugs not subject to pharmacy copay. | Coinsurance applies to the prescription $1,200 out-of-pocket annual maximum per person, $3,600 per family. Prescription Allowance on all non-sedating antihistamines (for allergy symptoms) and Proton Pump Inhibitors (for heartburn relief and ulcer treatment). City pays $20 per month, and plan participant pays remaining; some over the counter medications are also included. $5 copay for generic diabetic drugs and supplies, $15 copay for brand. Many contraceptive products are covered. IUDs and Depo Provera covered under the medical plan benefit. Coinsurance for asthma, anti-high cholesterol, and tobacco cessation drugs 10% for generic and 20% for brand pharmacy. | | | |
| **Prescription Drugs** (mail order) | | | | | |
| For a 90 day supply:<br>**Generic**: $45 copay<br>**Brand:** $90 copay | For a 90 day supply:<br>**Generic**: $30 copay<br>**Brand:** $60 copay | For a 90-day supply:<br>**Generic**: 30% coinsurance<br>**Brand**: 40% coinsurance<br>Minimum is $20 or double the cost of the drug if less. The maximum is $200 per drug. | Not Covered | For a 90-day supply:<br>**Generic**: 30% coinsurance<br>**Brand:** 40% coinsurance<br>Minimum is $20 or double the cost of the drug if less. The maximum is $200 per drug. | Not Covered |
| Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to the OOP Max. | | | | | |
| **Preventive Care** | | | | | |
| Paid at 100% after $15 copay<br>Covers adult physical and well child exams, most immunizations, hearing exams, eye exams, digital rectal exams/prostate-specific antigen test, colorectal cancer screening, pap smear exam and mammogram. | Paid at 100% after $15 copay<br>Covers adult physical and well child exams, most immunizations, hearing exams, eye exams, digital rectal exams/prostate-specific antigen test, colorectal cancer screening, pap smear exam and mammogram.<br>Hearing exams subject to deductible. | Mammograms paid at 80%. | Mammograms paid at 60% | Paid at 100% (copay waived)<br>Covers adult physical and well child exams, immunizations, digital rectal exams/prostate-specific antigen test, colorectal cancer screening. | Paid at 60% for well woman care and mammograms<br><br>No other preventive services covered |
| | | No other preventive services are covered | | | |
| **Rehabilitation Services** (inpatient) | | | | | |
| Paid at 100% after $200 copay per admission | Paid at 100% after deductible. | Paid at 80% after $200 copay | Paid at 60% after $200 copay | Paid at 90% after $200 copay | Paid at 60% after $200 copay |
| Maximum of 60 days per calendar year (combined with other therapy benefits) | | | | Maximum of 120 days per calendar year for skilled nursing and rehab services in- and out-of-network combined | |
| **Rehabilitation Services** (outpatient) | | | | | |
| Paid at 100% after $15 copay<br>Maximum of 60 visits per calendar year (combined with other therapy benefits) | $15 copay Deductible applies. | Paid at 80%<br>Includes medically necessary physical/massage, speech, and occupational therapy for non-chronic conditions. Coinsurance does not apply to OOP Max. Coverage of services subject to Aetna's review for medical necessity at any time | Paid at 60% | Paid at 100% after $15 copay<br>Includes medically necessary physical/massage, speech, occupational and cardiac/pulmonary therapy for non-chronic conditions. Coverage of services subject to Aetna's review for medical necessity at any time | Paid at 60% |

| Group Health Cooperative (GHC)* | | City of Seattle Traditional Plan* | | City of Seattle Preventive Plan* | |
|---|---|---|---|---|---|
| **Standard Plan** | **Deductible Plan** | **Aetna In-Network** | **Out-of-Network** | **Aetna In-Network** | **Out-of-Network** |
| **Skilled Nursing Facility** | | | | | |
| Paid at 100%. 60 day maximum per calendar year. | 60 day maximum per calendar year. Paid at 100% after deductible. | Paid at 80% after $200 copay<br>Maximum of 90 days per calendar year for in- and out-of-network combined | Paid at 60% after $200 copay | Paid at 90% after $200 copay<br>Maximum of 120 days per calendar year for rehab services and skilled nursing in- and out-of-network combined | Paid at 60% after $200 copay |
| **Smoking Cessation** | | | | | |
| Paid at 100% for individual or group sessions<br>Nicotine replacement therapy included in Prescription Drug benefit | Paid at 100% for individual or group sessions | Lifetime maximum of one 90-day supply of aids or drugs. Coinsurance 10% generic, 20% brand. See Prescription Drugs. | Not covered | Smoking cessation prescription drugs covered subject to 10% generic, 20% brand drug coinsurance. | Not covered |
| **Spinal Manipulations** | | | | | |
| Paid at 100% after $15 copay<br>Self-referral to GHC designated providers. Must meet GHC protocol. Maximum of 10 visits per calendar year. | $15 copay.<br>Deductible applies. | Paid at 80%<br>Maximum of 10 visits per calendar year for in-network and out-of-network combined. | Paid at 60% | Paid at 100% after $15 copay<br>Maximum of 20 visits per calendar year for in-network and out-of-network combined. | Paid at 60% |
| **Sterilization Procedures** | | | | | |
| Outpatient: Paid at 100% after $15 copay | Outpatient: $15 copay. Deductible applies. | Inpatient: Paid at 80% after $200 copay<br>Outpatient: Paid at 80% | Inpatient: Paid at 60% after $200 copay<br>Outpatient: Paid at 60% | Inpatient: Paid at 90% after $200 copay<br>Outpatient: Paid at 90% | Inpatient: Paid at 60% after $200 copay<br>Outpatient: Paid at 60% |
| **Temporomandibular Joint Services** | | | | | |
| Covered as any other service; copays/coinsurance depend on type and location of service provided. 5,000 lifetime maximum | Covered as any other service; copays/coinsurance depend on type and location of service provided.<br>$5,000 lifetime maximum | Covered as any other service; copays/coinsurance depend on type and location of service provided.<br>$5,000 lifetime maximum for non-surgical services in- and out-of-network combined. | Covered as any other service; copays/coinsurance depend on type and location of service provided. | Covered as any other service; copays/coinsurance depend on type and location of service provided.<br>$5,000 lifetime maximum for non-surgical services in- and out-of-network combined. | Covered as any other service; copays/coinsurance depend on type and location of service provided. |
| **Tooth Injury** (due to accident) | | | | | |
| Not covered | Not covered | Inpatient: Paid at 80% after $200 copay<br>Outpatient: Paid at 80% | Inpatient: Paid at 60% after $200 copay<br>Outpatient: Paid at 60% | Inpatient: Paid at 90% after $200 copay<br>Outpatient: Paid at 100% after $15 copay for office visit. Other charges paid at 90% | Inpatient: Paid at 60% after $200 copay<br>Outpatient: Paid at 60% |
| **Vision Exam/Hardware** | | | | | |
| Exam: Paid at 100% after $15 copay. One exam every 12 months.<br>Hardware: Not covered. | Exam: Paid at 100% after $15 copay. One exam every 12 months.<br>Hardware: Not covered. | Exam: Paid at 100%<br>Hardware: Two lenses per calendar year; $20-$40 per lens; frames; $30 every other year | | Exam: Paid at 100%<br>Hardware: Not covered. Discounts available through portal.eyemedvisioncare.com/wps/portal/emweb | |
| **X-ray and Lab Tests** | | | | | |
| Paid at 100% | Paid at 100%. Deductible applies. | Paid at 80%<br>Provider responsible for obtaining precertification of high tech radiology | Paid at 60% | Paid at 90%<br>Provider responsible for obtaining precertification of high tech radiology | Paid at 60% |

* Coverage for any service is subject to the carrier's determination of medical necessity and adherence to their clinical policy guidelines.

** Applies to Aetna -- Recognized charges are the lower of the provider's usual charge for performing a service, and the charge Aetna determines to be the recognized charge percentage in the geographic area where the service is provided.

*** Applies to Aetna – Aexcel network, a specialty network of doctors in 13 specialty areas. The coinsurance level will drop 10% for non-Aexcel doctors in the 13 specialty areas (coinsurance applies to in-network, out-of-pocket maximum). Call 1-877-292-2480for more information about the Aexcel network.

**Plan details are in your medical plan booklet** at seattle.gov/personnel/benefits/health/medical.asp. **This document is not a contract.**

## 2012 Medical Plan Highlights - City of Seattle Retirees Age 65 and Over

This is a brief highlight of plan benefits. This is not a contract. For complete benefit information and exclusions, consult plan booklets.

| | Original Medicare Parts A & B *2011 Information** | Aetna** Medicare Plan (PPO) | Group Health** Clear Care HMO Plan | United HealthCare** Medicare Complete HMO*** |
|---|---|---|---|---|
| **Plan Type** | Original Medicare | Medicare Advantage PPO | Medicare Advantage HMO | Medicare Advantage HMO |
| **Annual Deductible** | $162.00 (Part B) | $0 | $0 | $0 |
| **Out Of Pocket Cost Limitations** | | | | |
| Out of Pocket Maximum Limit per year | Varies dependent on service | $2,000 per individual | $2,500 per individual | $2,000 per individual |
| **Hospitalization** | | | | |
| Semiprivate room and board, general nursing and other hospital services and supplies in a medical facility | (Part A) Days 1- 60, all but $1,162 covered; days 61- 90, all but $283 a day; days 91- 150 (reserve days), all but $566 a day; beyond 150 days, $0 paid | $250 copay per admission | Covered in full. | 100% after $200 copay, per admission |
| **Skilled Nursing Facility Care** | | | | |
| Semiprivate room and board, skilled nursing and rehabilitation services/supplies | (Part A) First 20 days, 100% of approved amount; additional 80 days, all but $141.50 per day; beyond 100 days, $0 paid. | $0 copay days 1-10, $25 copay days 11-20, $50 copay days 21-100, up to 100 days per benefit period | Covered in full up to 100 days per benefit period. | $0 copay days 1-20, $50 copay days 21-100 up to 100 days per benefit period |
| **Physician Network** | | | | |
| | May use any provider that accepts Medicare payments | Must use Preferred (in-network) providers or those that accept Aetna Medicare Advantage reimbursement (Non-Preferred providers) | Must use providers that contract with Group Health | Must use providers that contract with Secure Horizons |
| **Physician Services** | | | | |
| Physician care in hospital, home, office and most outpatient ancillary services | 80% of approved amount subject to annual deductible | In-hospital visits covered at 100%. Outpatient visits covered in full after $20 copay per visit | In-hospital visits covered at 100%. Outpatient visits covered in full after $10 copay per visit | In-hospital visits covered at 100%. Outpatient visits covered in full after $10 copay per PCP visit; $20 copy per Specialist visit |

| | | | | |
|---|---|---|---|---|
| **Well Care** | | | | |
| Routine Physical Exams | One time only, within first 6 months of enrolling in Part B; covers 80% of approved amount after deductible | One annual exam covered in full (includes Colorectal Cancer Screening and Bone Density Testing) | One annual exam covered in full | One annual exam covered in full |
| Routine Mammography | 80% of approved amount | Covered in full one time per year | Covered in full one time per year | Covered in full one time per year |
| Routine Pap Smears | 80% of approved amount | Covered in full one time per year | Covered in full one time per year | Covered in full one time per year |
| Other Wellness Services | Smoking cessation, cancer screening | Telephonic coaching, Personal Health Record, Informed 24-hour health phone line, Aetna Smart Source, Aetna Navigator, disease management | Personal Health Profile, 24-hour consulting nurse phone line, telephonic coaching, wellness web site, disease management, Silver Sneakers, Enhance Fitness, | Senior Silver Sneakers Fitness Program, disease management, 24 hour nurse line, Treatment Decision Support. Personal Health Management Program |
| **Diagnostic Lab & X-ray** | | | | |
| | 80% of approved amount | Covered in full after $20 copay | Covered in full | Covered in full |
| **Mental Health and Alcohol/Drug Abuse** | | | | |
| Inpatient and Outpatient | Inpatient: Same deductible & co-payments as shown under Hospitalization.<br>Outpatient: 50% of approved amount for most services, subject to annual deductible | Inpatient: 100% after $250 copay per admission<br>Outpatient: 100% after $20 copay per individual visit | Inpatient: 100%. Limited to 190 days per lifetime; authorization required<br>Outpatient: $10 copay per visit, authorization required | Inpatient: 100% after $200 copay per admission. 190-day lifetime maximum.<br>Outpatient: 100% after: $20 copay per individual visit; $10 copay per group visit. Referral required |
| **Home Health Care** | | | | |
| Part-time or intermittent skilled care or home health aide services | 100% of approved amount for most services | Covered in full | Covered in full | Covered in full |
| Durable medical equipment/ supplies | Varies depending on service | 20% coinsurance | 20% coinsurance | 20% coinsurance |
| **Emergency Medical Care** | | | | |
| | | Urgent Care: $20 copay<br>Emergency Room: $50 copay<br>Ambulance: $20 copay | Urgent Care: $ $10 copay<br>Emergency Room: $65 copay<br>Ambulance: $150 copay | Urgent Care: $35 copay<br>Emergency Room: $50 copay<br>Ambulance: $50 copay |

| | Original Medicare | Aetna** | Group Health** | United HealthCare ** |
|---|---|---|---|---|
| | **Parts A & B** ***2011 Information**** | **Medicare Plan (PPO)** | **Clear Care HMO Plan** | **Medicare Complete HMO*** ** |
| **Rehabilitation** | | | | |
| Speech, Physical And Occupational Therapy | 80% for inpatient and outpatient services | Inpatient: 100% after $250 copay per admission<br>Outpatient: $20 copay per visit | Inpatient: 100% after $100/day copay up to a 3-day maximum per admission<br>Outpatient: $10 copay per visit. | Inpatient: 100% after $200 copay per admission<br>Outpatient: $25 copay per visit |
| **Prescription Drugs** | | | | |
| | Retiree selects a prescription Part D plan from a vendor, and pays a premium for the plan selected; for more info, visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), TTY users should call 1-877-486-2048 | **Initial Coverage Period**:<br>Retiree copays for 1 month retail/3 months mail order:<br><br>Preferred Generic: $5/$12.50<br>Non Pref Generic: $25/$62.50<br>Preferred Brand: $40/$100<br>Non-Pref Brand: $65/$162.50<br>Specialty: 25%/25%<br><br>**Gap**: After retiree and plan spends $2,930 (in Initial Coverage Period), retiree pays:<br><br>Preferred Generic*: $5/$12.50<br>Non Pref Gen*: $25/$62.50<br>Preferred Brand*: 100%<br>Non-Pref Brand*: 100%<br>Specialty*:<br>86% Gen, 86% Brand<br><br>**Catastrophic:** Once $4,700 in true out-of-pocket costs is reached, retiree pays the greater of: $2.60 or 5% for Generic drugs; $6.50 or 5% for all other covered drugs | Retiree copays for 30-day supply purchased at GHC facility:<br><br>Generic: $10 copay<br>Brand: $40 copay<br>Nonformulary: 50%<br><br>Some exclusions apply.<br>Copays do not apply toward out of pocket maximum.<br><br>Mail Order: 90-day supply through GHC mail order pharmacy.<br>Generic: $20 copay<br>Brand: $80 copay<br>Nonformulary: 50% | **Initial Coverage Period**:<br>Retiree copays for 1 month retail/3 months mail order:<br><br>Preferred Generic: $4/$8<br>Preferred Brand: $28/$74<br>Non Pref Brand: $58/$164<br>Pref Speciality: 33%/33%<br><br>**Gap**: After retiree and plan spends $2,840 (in Initial Coverage Period), retiree pays 100%<br><br>**Catastrophic:** Once $4,770 in true out-of-pocket costs is reached, retiree pays the greater of: $2.60 or 5% for Generic drugs; $6.50 or 5% for all other covered drugs |

| | Original Medicare Parts A & B *2011 Information** | Aetna** Medicare Plan (PPO) | Group Health** Clear Care HMO Plan | United HealthCare ** Medicare Complete HMO*** |
|---|---|---|---|---|
| **Vision Care** | | | | |
| Exams | Not covered | Covered in full one time per year | Covered in full once every 12 months after $ $10copay | Covered in full one time per year after $20 copay |
| Eyeglass Lenses & Frames | Not covered, with the exception of one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens | Discounts where available | $100 hardware allowance every 24 months. | Not covered |
| Contact Lens Exam & Lenses | Not covered | Discounts where available | Discounts available at gheyecare.org | Not covered |
| **Hearing Exams And Hearing Aids** | | | | |
| Exams | Routine exam not covered | Covered in full one time per year | Covered in full after $10 copay per visit | Covered in full one time per year |
| Hearing Aids | Not covered | Discounts where available | Covered up to $250 every 24 months; must be purchased through GHC | Covered up to $500 every 3 years |
| **Other Services** | | | | |
| | | Diabetic supplies covered at 100% | | |
| **Monthly Rates** | | | | |
| All rates are Per Person Per Month | Part B premium: $115.40 for income of $85,000 or less (income of $170,000 or less for joint filers). **** | **Washington State residents:** Part B premium plus $187.00; **Non-Washington State residents:** Part B premium plus $257.98 | Part B premium plus $248.15 | Part B premium plus $261.81 |

*Original Medicare Parts A & B information is not available for 2012; when available, updated comparison charts will be posted on the Retirement website.
**Benefits shown presume that members have Medicare Parts A & B coverage (dependents without Medicare coverage have a different schedule of benefits) and that services provided follow Medicare guidelines. "Year" refers to the calendar year, unless indicated otherwise. For Group Health and Secure Horizons plans, services must be obtained from approved network providers. For Aetna plans, services must be obtained from Preferred network providers or from Non-Preferred providers willing to accept the Aetna Medicare Advantage payment; there is no reimbursement for non-participating providers.
***The service area does not include Skagit and Whatcom counties.
****Premium amounts for higher income levels at:
https://questions.medicare.gov/app/answers/detail/a_id/2306/kw/2012%20Part%20B%20Premium%20Amounts%20for%20Persons

# City of Seattle

**Michael Patrick McGinn, Mayor**

**Personnel Department**
David L. Stewart, Personnel Director


October 21, 2011

**These notices are for your information only. No immediate action is required.**

Dear City of Seattle Retiree:

The City of Seattle provides important information/notices annually so that you know your City health care coverage rights and responsibilities. This mailing includes four notices - not all of the notices may apply to the medical plan and/or coverage you have elected.

- **File the documents with your other important papers** so that you can refer to them later. Notice content is summarized below for your reference.

**Women's 1998 Health and Cancer Rights Act**

→ Applies to retirees with medical coverage and to their enrolled spouse/domestic partner or child(ren).
→ States that the plans provide benefits for mastectomy-related services such as breast reconstruction and surgery to achieve symmetry.

**Grandfathered Plan Notice**

→ Applies to retirees with medical coverage and to their enrolled spouse/domestic partner or child(ren).

**Medicare Part D (Creditable Coverage)**

→ Applies to members enrolled in the City of Seattle's self-insured medical plans administered by Aetna. For Group Health and Secure Horizons members, contact the carrier directly for the Medicare Part D notice if you need it.
→ Confirms your prescription drug coverage is at least as good as Medicare Part D coverage.
→ Advises when someone can enroll in Medicare Part D.
→ Advises how to preserve your rights to enroll in Medicare Part D without incurring the permanent 1% per month penalty for not having credible prescription drug coverage. **Provide a copy** of this Notice when applying for Medicare Part D coverage.

**Initial Notice of COBRA Continuation Coverage Rights**

→ Applies to retirees with medical/dental coverage if they have enrolled a spouse/domestic partner or child(ren).
→ Advises the retiree-employee and covered dependents of their rights and responsibilities regarding group coverage continuation should coverage end due to a qualifying event.

**Notice of Privacy Practices**

→ Applies to members enrolled in the City of Seattle's self-insured medical plan administered by Aetna. For Group Health and Secure Horizons members, contact the carrier directly for a copy of the carrier's Privacy Practices.

→ Describes how your medical information may be used and disclosed, and your rights regarding your medical information.

**Medicaid and the Children's Health Insurance Program (CHIP) Notification**

→ Notification of premium assistance.

**Contact Information:**

| | | |
|---|---|---|
| Aetna | 877-292-2480 | www.aetnanavigator.com |
| Group Health | 888-901-4636 | www.ghc.org |
| SecureHorizons – HMO | 800- 533-2743 | |
| Retiree Dental | 253-862-2122 | |
| City of Seattle, Retirement<br>720 Third Ave, Suite<br>Seattle WA 98104-1829 | 206-386-1293 | www.seattle.gov/retirement/<br>email: retirecity@seattle.gov |
| City of Seattle, Personnel<br>Benefits Unit<br>PO Box 34028<br>Seattle WA 98124-4028 | 206-615-1340 | email: benefitu@seattle.gov |

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**Women's 1998 Health and Cancer Rights Act**

****Annual Notice****

As required by the Women's Health and Cancer Rights Act of 1998, the group health plans offered by the City of Seattle provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

A group health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles, copays, and/or coinsurance amounts that are consistent with those that apply to other benefits under the plan. Contact your health plan for more information.

**Health Care Reform Notice -- Grandfathered Plan Status Disclosure**

The City of Seattle Aetna, United Healthcare, and Group Health medical plans are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions? Contact Central Benefits at (206) 615-1340.

## Important Notice from the City of Seattle About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Seattle and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. City of Seattle has determined that the prescription drug coverage offered by the Aetna, Group Health, and United Health Care is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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### When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15 through December 31.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

### What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City of Seattle coverage will be affected. Your current prescription drug plan coverage is part of City of Seattle medical plan. You cannot drop your City of Seattle prescription drug coverage unless you also drop your City of Seattle medical coverage. If your enroll in a Medicare part D plan and drop your creditable coverage with City of Seattle, you and your dependents may not be able to return to the City of Seattle plan until the next annual open enrollment period. It is important that you compare your current plan, including which drugs are covered, with the coverage and costs of Medicare part D plans.

If you do decide to join a Medicare drug plan and drop your current City of Seattle coverage, be aware that you and your dependents will not be able to get this coverage back.

### When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with City of Seattle and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

**For More Information About This Notice Or Your Current Prescription Drug Coverage...**

Contact your medical plan for further information. **NOTE:** You'll receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan, and if this coverage through City of Seattle changes. You also may request a copy of this notice at any time.

**For More Information About Your Options Under Medicare Prescription Drug Coverage...**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember: Keep this Creditable Coverage notice.** If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

| | |
|---|---|
| Date: | 11/1/2011 |
| Name of Entity/Sender: | City of Seattle |
| Contact--Position/Office: | Personnel Department/Benefits Unit |
| Address: | P.O. Box 34028 MS SMT- 55-01<br>Seattle, WA 98124-4028 |
| Phone Number: | 206-615-1340 |

**CMS Form 10182-CC** **Updated January 1, 2011**

# INITIAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
# **CONTINUATION COVERAGE RIGHTS UNDER COBRA **

**Introduction**
It is important that all covered individuals (employee, spouse/domestic partner, and eligible dependent children, if able) take the time to read this notice carefully and be familiar with its contents. If there is a covered dependent not living at your address, please provide written notification to your department's Benefits Representative so a notice can be sent to that dependent as well.

You are receiving this notice because you may have recently become covered under one or more of the following group health plans: City of Seattle Preventive Plan, City of Seattle Traditional Plan, Group Health Cooperative, Washington Dental Service, Dental Health Services, Vision Service Plan, United HealthCare, and the Health Flexible Spending Account (Health FSA). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under a plan under certain circumstances when coverage would otherwise end due to a qualifying event. This notice generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. COBRA (and the description of COBRA coverage contained in this notice) applies only to the group health plans listed above (medical, dental, vision, and the Health FSA) and not to any other benefits offered by the City of Seattle (such as life insurance, long term disability, or accidental death and dismemberment insurance). **Should an actual qualifying event occur in the future, the City of Seattle will send you additional information and an election notice at that time.**

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under a plan. It can also become available to your spouse/domestic partner and dependent children, if they are covered under a plan, when they would otherwise lose their group health coverage under the plan. This notice does not fully describe COBRA coverage or other rights under a plan. For additional information about your rights and obligations under a plan and under federal law, you should review the plan booklet or contact the City of Seattle Personnel Department Benefits Unit, which is the COBRA Plan Administrator. A plan provides no greater COBRA rights than what COBRA requires – nothing in this notice is intended to expand your rights beyond COBRA's requirements.

**What is COBRA Continuation Coverage?**
COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed in this notice. After a qualifying event occurs and any required notice of that event is properly provided to your department's Benefits Representative, COBRA coverage must be offered to each person losing plan coverage who is a "qualified beneficiary." You, your spouse/domestic partner, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under a plan is lost because of the qualifying event. Under a plan, qualified beneficiaries who elect COBRA coverage must pay for COBRA coverage.

**Who is entitled to elect COBRA Continuation Coverage?**
If you are an employee, you will be entitled to elect COBRA coverage if you lose your group health coverage under a plan because either one of the following qualifying events happens:

- your hours of employment are reduced, or
- your employment ends for any reason.

If you are the spouse/domestic partner, you will be entitled to elect COBRA coverage if you lose your group health coverage under a plan because any of the following qualifying events happens:

- your spouse/domestic partner dies;
- your spouse's/domestic partner's hours of employment are reduced;

- your spouse's/domestic partner's employment ends for any reason other than his or her gross misconduct; or
- you become divorced or legally separated from your spouse, or you terminate your domestic partnership. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation occurs within three months of the reduction or elimination of coverage, then the divorce or legal separation will be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or legal separation.

A person enrolled as the employee's dependent child will be entitled to elect COBRA if he or she loses group health coverage under a plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The child stops being eligible for coverage under a plan as a "dependent child."

**When is COBRA Continuation Coverage Available?**

When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, a COBRA election notice will be made available to qualified beneficiaries. You do not need to notify the Benefits Representative in your department of the occurrence of any of these three qualifying events. However, notice must be provided to your department's Benefits Representative for other qualifying events, as explained below in the section entitled "You Must Give Notice of Some Qualifying Events."

**You Must Give Notice of Some Qualifying Events**

For the other qualifying events (divorce or legal separation of the employee and spouse, termination of domestic partnership, or a dependent child's loss of eligibility for coverage as a dependent child), a COBRA election notice will be available to you only if you complete and submit a *Health Care Benefits Change Form* to the Benefits Representative for your department within 60 days after the date on which the qualified beneficiary loses or would lose coverage under the terms of the plan as a result of the qualifying event. If this procedure is not followed during the 60-day notice period, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA COVERAGE. (A *Health Care Benefits Change Form* is available from your department's Benefits Representative.)

**Electing COBRA Coverage**

Each qualified beneficiary will have an independent right to elect COBRA coverage. Covered employees and spouses/domestic partners (if the spouse/domestic partner is a qualified beneficiary) may elect COBRA coverage on behalf of all of the qualified beneficiaries and parents may elect COBRA coverage on behalf of their children. Any qualified beneficiary for whom COBRA coverage is not elected within the 60-day election period specified in the COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied.

**How Long Does COBRA Coverage Last?**

COBRA coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the covered employee's divorce, legal separation or termination of domestic partnership; or a dependent child's losing eligibility as a dependent child, COBRA coverage can last for up to a total of 36 months. However, COBRA coverage under the Health FSA component can last only until the end of the year in which the qualifying event occurred. (See the paragraph below entitled "Health FSA Component.")

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months BEFORE the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage for his spouse/domestic partner and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). However, COBRA coverage under the Health FSA component can last only until the end of the year in which the qualifying event occurred. (See the paragraph below entitled "Health FSA Component.")

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months. However, COBRA coverage under the Health FSA component can last only until the end of the year in which the qualifying event occurred. (See the paragraph below entitled "Health FSA Component."

**Extension of Maximum Coverage Period**
If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the COBRA Plan Administrator of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage. (The period of COBRA coverage under the Health FSA cannot be extended under any circumstances.)

***Disability extension of 18-month period of continuation coverage***
If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA Plan Administrator in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above.)

The disability extension is available only if you complete and submit a *Notice of Disability* and a copy of the Social Security Administration's determination of disability to the COBRA Plan Administrator: (a) during the 18 months after the covered employee's termination of employment or reduction of hours, and (b) within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of a plan as a result of the covered employee's termination of employment or reduction of hours.

If these procedures are not followed or if the notice is not provided to the COBRA Plan Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE. You can obtain a copy of a *Notice of Disability* from the COBRA Plan Administrator.

***Second qualifying event extension of COBRA coverage***
If your family experiences another qualifying event while receiving COBRA coverage because of the covered employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the spouse/domestic partner and dependent children receiving COBRA coverage can get up to 18 additional months of COBRA

coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the COBRA Plan Administrator. This extension may be available to the spouse/domestic partner and any dependent children receiving COBRA coverage if the employee or former employee dies; gets divorced or legally separated, or terminates a domestic partnership; or if the dependent child stops being eligible under a plan as a dependent child, but only if the event would have caused the spouse/domestic partner or dependent child to lose coverage under a plan had the first qualifying event not occurred. (This extension is not available to the spouse/domestic partner and any dependent children under a plan when a covered employee becomes entitled to Medicare after electing COBRA coverage .)

This extension due to a second qualifying event is available only if you notify the COBRA Plan Administrator by completing and submitting a *Notice of Second Qualifying Event* within 60 days after the date of the second qualifying event. You can obtain a copy of a *Notice of Second Qualifying Event* from the COBRA Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the COBRA Plan Administrator during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.

**Health Care FSA Component**

COBRA coverage under the Health Care FSA will be offered to qualified beneficiaries. Health Care FSA COBRA coverage will consist of the Health Care FSA COBRA coverage that will be charged for the remainder of the plan year. Health Care FSA COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and Health Care FSA COBRA coverage will terminate at the end of the plan year.

**More Information About Individuals Who May Be Qualified Beneficiaries**

- *Children born to or placed for adoption with the covered employee during COBRA coverage period*

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in a plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in a plan, the child must satisfy the otherwise applicable plan eligibility requirements (for example, regarding age).

- *Alternate recipients under QMCSOs*

A child of the covered employee who is receiving benefits under a plan pursuant to a qualified medical child support order (QMSCO) received by the COBRA Plan Administrator during the covered employee's period of employment with the City of Seattle is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

**Keep Your Plan Informed of Address Changes**

In order to protect your family's rights, you should keep your department's Benefits Representative informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your department's Benefits Representative or COBRA Plan Administrator.

**If You Have Questions**

Questions concerning your Plan or COBRA coverage should be addressed to the:

COBRA Plan Administrator
City of Seattle Personnel Department
Benefits Unit
700 5th Ave., Suite 5500
PO Box 34028
Seattle, WA 98124-4028 **Phone**: 206-684-4659

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

## Safeguarding Your Protected Health Information

The City of Seattle self-insured medical group health plan administered by Aetna, Inc.. (the "Plan") is designed to protect the privacy of your health information. The Plan is required by applicable federal and state laws to maintain the privacy of your Protected Health Information. This notice explains the Plan's privacy practices, their legal duties, and your rights concerning your Protected Health Information (referred to in this notice as "PHI"). The term "PHI" includes any information that is personally identifiable to you and that is transmitted or maintained by the Plan, regardless of form (oral, written, electronic). This includes information regarding your health care and treatment, and identifiable factors such as your name, age, and address. The Plan will follow the privacy practices described in this notice while it is in effect.

### Why does the Plan collect Protected Health Information?

The Plan collects PHI for a number of reasons, including to determine the appropriate benefits to offer individuals, to pay claims, to provide case management services, and to provide quality improvement services.

### How does the Plan collect Protected Health Information?

The Plan collects PHI through covered members, their health care providers, and the Plan's Business Associates. For example, the Plan's claims administrators, which are Business Associates, receive PHI from health care providers, such as through the submission of a claim for reimbursement of covered benefits.

### How does the Plan safeguard your Protected Health Information?

The Plan protects your PHI by:

- Treating all of your PHI that is collected as confidential;
- Stating confidentiality policies and practices in the Plan's group health plan administrative procedure manual, as well as disciplinary measures for privacy violations;
- Restricting access to your PHI to those individuals who need to know your personal information in order to provide services to you, such as paying a claim for a covered benefit;
- Only disclosing your PHI that is necessary for a service company to perform its function on the Plan's behalf, and the company agrees to protect and maintain the confidentiality of your PHI; and
- Maintaining physical, electronic, and procedural safeguards that comply with federal and state regulations to guard your PHI.

### How does the Plan use and disclose your Protected Health Information?

The Plan will not disclose your PHI unless they are allowed or required by law to make the disclosure, or if you (or your authorized representative) give the Plan permission. Uses and disclosures, other than those listed below, require your authorization. If you authorize a Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use your PHI for the reasons covered by the written authorization. If there are other legal requirements under applicable state laws that further restrict a Plan's use or disclosure of your PHI, it will comply with those legal requirements as well. Following are the types of disclosure the Plan may make as allowed or required by law:

- **Treatment**: They may use and disclose your PHI for the treatment activities of a health care provider. It also includes consultations and referrals between one or more of your providers. Treatment activities include disclosing your PHI to a provider in order for that provider to treat you.

- **Payment:** They may use and disclose your medical information for their payment activities, including the payment of claims from physicians, hospitals and other providers for services delivered to you. Payment also includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, utilization review and preauthorizations).

For example, a Plan may tell a physician whether you are eligible for benefits or what percentage of the bill will be paid by the Plan.

- **Health Care Operations:** They may use and disclose your medical information for their internal operations, including their customer service activities. Health care operations include but are not limited to quality assessment and improvement, disease and case management, medical review, auditing functions including fraud and abuse compliance programs and general administrative activities.

- **Business Associates:** They may also share PHI with third party "business associates" who perform certain activities for the Plan. They require these business associates to afford your PHI the same protections afforded by themselves.

- **Plan Sponsor:** They may disclose your PHI to the Plan's sponsor with your authorization or when required by law to permit it to perform administrative activities.

- **To You or Your Authorized Representative:** Upon your request, a Plan will disclose your PHI to you or your authorized representative. If you authorize a Plan to do so, it may use your PHI or disclose it to the person or entity you name on your signed authorization. After you provide a Plan with an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. In certain situations when disclosure of your information could be harmful to you or another person, a Plan may limit the information available to you, or use an alternative means of meeting your request.

- **To Your Parents, if You are a Minor:** Some state laws concerning minors permit or require disclosure of PHI to parents, guardians, and persons acting in a similar legal status. The Plan will act consistently with the laws of the state where the treatment is provided, and will make disclosures consistent with such laws.

- **Your Family and Friends:** If you are unable to consent to the disclosure of your PHI, such as in a medical emergency, a Plan may disclose your PHI to a family member or friend to the extent necessary to help with your health care or with payment for your health care. A Plan will only do so if it determines that the disclosure is in your best interest.

- **Research; Death; Organ Donation:** They may use or disclose your PHI for research purposes in limited circumstances. They may disclose the PHI of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.

- **Public Health and Safety:** They may disclose your PHI if they believe disclosure is necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. They may disclose your PHI to appropriate authorities if they reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.

- **Required by Law:** They must disclose your PHI when they are required to do so by law, including workers' compensation laws.

- **Process and Proceedings:** They may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.

- **Law Enforcement:** They may disclose limited information to law enforcement officials.

- **Military and National Security:** They may disclose to military authorities the PHI of Armed Forces personnel under certain circumstances. They may disclose to authorized federal officials PHI required for lawful intelligence, counterintelligence, and other national security activities.

**What rights do you have as an individual regarding a Plan's use and disclosure of your Protected Health Information?**

You have the right to request all of the following:

- **Access to your PHI:** You have the right to review and receive a copy of your PHI. Your request must be in writing. A Plan may charge you a nominal fee for providing you with copies of your PHI. This right does not include the right to obtain copies of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to other state or federal laws that prohibit a Plan from releasing such information. A Plan may also limit your access to your PHI if they determine that providing the information could possibly harm you or another person; you have the right to request a review of that decision.

- **Amendment:** You have the right to request that a Plan amend your PHI. Your request must be in writing, and it must identify the information that you think is incorrect and explain why the information should be amended. A Plan may decline your request for certain reasons, including if you ask it to change information that it did not create. If a Plan declines your request to amend your records, it will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If a Plan accepts your request to amend the information, it will make reasonable efforts to inform others, including people you have authorized, of the amendment and to include the changes in any future disclosures of that information.

- **Accounting of Disclosures:** You have the right to receive a report of instances in which a Plan or its business associates disclosed your PHI for purposes other than for treatment, payment, health care operations, and certain other activities. You are entitled to such an accounting for the 6 years prior to your request, though not for disclosure made prior to April 14, 2003. A Plan will provide you with the date on which it made a disclosure, the name of the person or entity to whom it disclosed your PHI, a description of the PHI it disclosed, the reason for the disclosure, and other applicable information. If you request this list more than once in a 12-month period, a Plan may charge you a reasonable fee for creating and sending these additional reports.

- **Restriction Requests:** You have the right to request that a Plan place additional restrictions on its use or disclosure of your PHI for treatment, payment, health care operations or to

persons you identify. It may be unable to agree to your requested restrictions. If the Plan does, it will abide by its agreement (except in an emergency).

- **Confidential Communication:** You have the right to request that a Plan communicate with you in confidence about your PHI by alternative means or to an alternative location. If you advise a Plan that disclosure of all or any part of your PHI could endanger you, it will comply with any reasonable request provided you specify an alternative means of communication.

- **Electronic Notice:** If you receive this notice on the Plan sponsor's Web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact the Plan using the information listed at the end of this notice to obtain this notice in written form.

**Can I "opt out" of certain disclosures?**

You may have received notices from other organizations that allow you to "opt out" of certain disclosures. The most common type of disclosure that applies to "opt outs" is the disclosure of personal information to a non-affiliated company so that company can market its products or services to you. Self-insured group health plans must follow many federal and state laws that prohibit them from making these types of disclosures. Because they do not make disclosures that apply to "opt outs," it is not necessary for you to complete an "opt out" form or take any action to restrict such disclosures.

**When is this notice effective?**

***This notice takes effect April 14, 2003 and will remain in effect until the Plan revises it.***

*What if the Plan changes their notice of privacy practices?*

***The Plan reserve the right to change their privacy practices and the terms of this notice at any time and to make the revised or changed notice effective for PHI they already have about you, as well as any information they receive in the future, provided such changes are permitted by applicable law. Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, your individual rights, the Plan's duties or other privacy practices stated in this notice. For your convenience, a copy of the Plan's current notice of privacy practices is always available on the Plan's sponsor's Web site at*** *http://inweb/personnel/benefits/docs/NoticeofPrivacyPractices.DOC,* ***and you may request a copy at any time by contacting the Plan's Privacy Officer at the number listed below.***

*Conclusion*

***PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.***

**How can you reach us?**

If you want additional information regarding the Plan's Privacy Practices, or if you believe the Plans have violated any of your rights listed in this notice, please contact the Plan's Privacy Officer at City of Seattle Personnel Department, Benefits Unit, 700 5th Avenue, Suite 5500, Seattle, WA 98104; 206-7957. If you have a complaint, you also may submit a written complaint to the U.S. Department of Health and Human Services, 2201 6th Ave., Suite 900, Seattle, WA 98121-1831 or by e-mail to OCRComplaint@hhs.gov. Your privacy is one of the Plan's greatest concerns and there is never any penalty to you if you choose to file a complaint with the Plan's Privacy Officer or with the U.S. Department of Health and Human Services.

**Medicaid and the Children's Health Insurance Program (CHIP)**
**Offer Free Or Low-Cost Health Coverage To Children And Families**

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

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You may be eligible for assistance paying your employer health plan premiums. Contact the Medicaid office for Washington for further information on eligibility.

**Washington – Medicaid**

Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm

Phone: 1-800-562-3022 ext. 15473

For more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565